

Confidential Fax

To:	EXAMPLE HOSPITAL	From:	NAME x3814
Fax:	1999999999	Pages:	2 (including cover page)
Phone:	9999999999	Date:	November 14, 2023
Re:	Request for repeat newborn screen	ATTN:	DOCTOR, EXAMPLE

x URGENT PLEASE COMMENT FOR REVIEW x PLEASE REPLY

Enclosed, please find an **URGENT** unsatisfactory report for the above named infant. A repeat sample is required **AS SOON AS POSSIBLE** to complete testing. Original reports will follow by mail.

Please confirm the receipt of this repeat collection request either by:

Calling 613-738-3222 x0

OR

Completing the information below and faxing this cover page back to:

1-855-933-2296 **this will fax back to Tanya Beatty's email inbox**

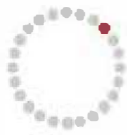
Confirmation of **URGENT** unsatisfactory sample request received

Completed by (please print): _____ Phone #: _____

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IF COPIES ARE UNCLEAR OR PAGES MISSING, CONTACT THE OFFICE AT (613) 738-3222.





Health Card Number/Type: [REDACTED]
NSO Episode Number: NXXXXXXXX-XXXX
Submitting Facility: EXAMPLE HOSPITAL

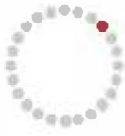
Date of Birth: [REDACTED]
Sex: [REDACTED]
Submitter MRN: [REDACTED]

SCREENING OUTCOMES - PRELIMINARY REPORT

<u>Test</u>	<u>Screening Result</u>
Amino Acidemias:	
Phenylketonuria and Variants / Biopterin Defects	Negative
Maple Syrup Urine Disease	Negative
Homocystinuria (Hypermethionemias)	Negative
Citrullinemias / Argininosuccinic Aciduria	Negative
Tyrosinemias	Negative
Amino Acidopathies, other	Negative
Organic Acidemias:	
Propionic / Methylmalonic Acidemias	Negative
Isovaleric Acidemia / 2 Methylbutyric Acidemias	Negative
Glutaric Acidemia Type 1	Negative
Guanidinoacetate Methyltransferase Deficiency	UNSATISFACTORY
Organic Acidemias, other	Negative
Fatty Acid Oxidation Defects:	
Medium Chain Acyl Dehydrogenase Deficiency	Negative
Very Long Chain Acyl Dehydrogenase Deficiency	Negative
Long Chain Hydroxyl Acyl Dehydrogenase / Trifunctional Protein Deficiencies	Negative
Carnitine Uptake Defect	Negative
Fatty Acid Oxidation Disorders, other	Negative
Galactosemia	Negative
Biotinidase Deficiency	Negative
Endocrine Disorders:	
Congenital Hypothyroidism	Negative
Congenital Adrenal Hyperplasia	Negative
Sickle Cell and other Hemoglobinopathies	Negative
Cystic Fibrosis	Negative
Severe Combined Immune Deficiency	Negative
Spinal Muscular Atrophy	Negative
Mucopolysaccharidosis Type 1H	UNSATISFACTORY

**This sample was not satisfactory for testing for the disease(s) indicated above.
A REPEAT SAMPLE IS REQUIRED AS SOON AS POSSIBLE.**





Confidential Fax

To:	EXAMPLE HOSPITAL	From:	NAME x3814
Fax:	1999999999	Pages:	2 (including cover page)
Phone:	9999999999	Date:	October 16, 2023
Re:	Request for repeat newborn screen	ATTN:	DOCTOR, EXAMPLE

URGENT PLEASE COMMENT FOR REVIEW x PLEASE REPLY

Enclosed, please find an unsatisfactory report for the above named infant. A repeat sample is required to complete testing. Original reports will follow by mail.

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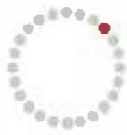
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Health Card Number/Type: [REDACTED]
NSO Episode Number: NXXXXXXXX-XXXX
Submitting Facility: EXAMPLE HOSPITAL

Date of Birth: [REDACTED]
Sex: [REDACTED]
Submitter MRN: [REDACTED]

SCREENING OUTCOMES - PRELIMINARY REPORT

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Propionic / Methylmalonic Acidemias	Negative
Isovaleric Acidemia / 2 Methylbutyric Acidemias	Negative
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Galactosemia	Negative
Biotinidase Deficiency	Negative
Endocrine Disorders:	
Congenital Hypothyroidism	Negative
Congenital Adrenal Hyperplasia	UNSATISFACTORY
Sickle Cell and other Hemoglobinopathies	Negative
Cystic Fibrosis	Negative
Severe Combined Immune Deficiency	Pending
Spinal Muscular Atrophy	Pending
Mucopolysaccharidosis Type 1H	Negative

**This sample was not satisfactory for testing for the disease(s) indicated above.
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